STATE OF CALIFORNIA**SQ**HEALTH AND WELFARE AGENCY PETE WILSON, Governor
DEPARTMENT OF ALCOHOL AND DRUG PROGRAMS
1700 K STREET
SACRAMENTO, CA 95814-4037
TTY (916) 445-1942
(916) 322-7012

October 16, 1995

ADP 95-45

To: County Alcohol And Drug Program Administrators
Drug/Medi-Cal Certified Providers

Subject: Drug/Medi-Cal Billing Claim Guidelines for Fiscal Year (FY) 1995-96

ADP Letters 95-32 and 95-36, as well as the initial letter dated August 9, 1995 and the letter of September 28, 1995, informing counties and Drug/Medi-Cal (D/MC) providers of changes in Drug/Medi-Cal benefits and reimbursement rates have generated a number of questions regarding claims preparation and processing. This letter offers guidance for the processing of Drug/Medi-Cal claims.

I. Changes Affecting Claims Submission for FY 1995-96:

AB 911, Chapter 305, Statutes of 1995, which became effective August 3, 1995, restructured the Outpatient Drug Free (ODF) modality into Individual ODF (based on a 50 minute session) and Group ODF (based on a 90 minute session). The group ODF is also changed to a rate which applies to the Medi-Cal portion of an entire group session as a unit of service. In addition, ADP is implementing regulations which will limit Individual ODF to intake (including evaluation, assessment and diagnosis), crisis intervention, collateral services, and treatment and discharge planning.

Drug/Medi-Cal claims for services after July 1, 1995, need to be adjusted prior to submission for the following reasons:

1. New rates for all Drug/Medi-Cal modalities as set forth by the FY 1995-96 Budget Act are effective July 1, 1995. ADP has requested Department of Health Services (DHS) to establish edits in the system to limit claims to the new rate maximums; ADP 1592 invoices should be based on provisional rates which do not exceed the new rate maximums.

2. Under Medi-Cal, Perinatal refers to D/MC programs for pregnant and postpartum women only, regardless of the modality. Claims require adjustment where counties and providers formerly claimed parenting women under the Perinatal D/MC coding. Parenting women otherwise eligible for regular D/MC services may be claimed under regular D/MC, for Outpatient Methadone Maintenance (OMM) and Outpatient Drug Free (ODF) treatment services.

3. Day Care Habilitative Perinatal clients must be billed by Perinatal certified providers under the perinatal code (25). Day Care Habilitative clients who do not meet the pregnant and postpartum definition may be claimed under regular D/MC through September 14, 1995. Effective September 15, 1995, the DCH benefit applies only to protected populations, i.e. pregnant and postpartum women, and youth under 21 eligible under the Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT). DCH Services for parenting women may be paid for with PTEP SGF or SAPT Block Grant Funds.

4. Perinatal Residential clients must meet the pregnant and postpartum definition to be claimed under Drug/Medi-Cal.

5. Effective the date of adoption of emergency regulations, Outpatient Drug Free individual counseling will be allowable only if provided for intake (including evaluation, assessment and diagnosis), crisis intervention, collateral services, and treatment and discharge planning. Individual counseling sessions will be reimbursed at the lower of actual cost or charges up to a maximum of $73.46 for a 50 minute session. Please note that this change will affect the allowability of cost as well as its billing as a unit of service (UOS). After the effective date of regulations, where costs and UOS for individual counseling are included in billings for services which are no longer allowable, it is preferable to adjust claims, rather than create disallowed UOS and/or costs. ADP will inform all counties and Drug/Medi-Cal providers of the effective date of adoption of the emergency regulations, which is expected to occur in October 1995.

6. Effective August 3, 1995, the date of the enactment of AB 911, Outpatient Drug Free group counseling is reimbursed at lower of cost or charges up to a maximum maximum rate of $73.46 per 90 minute session. Because the maximum rate applies to the group session rather than the each D/MC individual in the group, claims submitted under old rate maximum per individual will result in significant overpayments. Such payments in excess of the maximum rate are prohibited.

   ADP cannot intercept all claims which exceed actual cost but are within the maximum rate; however, these claims will be detected during cost report settlement. Unfortunately, failure to adjust these claims will cause State General Fund to be encumbered until cost report settlement, making it unavailable for reallocation to the Negotiated Net Amount (NNA) contracts.

7. For Outpatient Drug Free services, the Service Function Code (SFC) must currently be in the range of 80-89. To differentiate between ODF Individual and ODF Group, 80-84 shall be the range for Individual and 85-89 for Group services as of August 3, 1995.

Specific Instructions for Completing Claim Forms:

1. On the Drug/Medi-Cal claim form (ADP 1584) the Service Function Code for Outpatient Drug Free is changed as follows:

Modality	SFC
ODF Individual	80 - 84
ODF Group	85 - 89

Beginning August 3, 1995, claims must indicate the appropriate SFC to differentiate individual from group.

2. For Group ODF, continue to indicate 1 Unit of Service in the UOS field, even though after August 3, 1995, the UOS is the entire group session. An entry other than 1 UOS will cause a critical edit and require error correction. The "UOS" recorded for a person under ODF Group is actually a visit rather than a true unit of service. Group sessions will have to be accounted for outside of the claim forms. However, the data recorded in the UOS field is useful and necessary to determine the cost per visit, as discussed below.

3. For your convenience, the Department has developed a Lotus 123 worksheet (hard copy with Wordperfect 5.1 instructions and disk enclosed) for development of provisional rates. Lotus version 2.3 or higher with WYSIWYG is required to operate the diskette. The file name is AVERAGE.WK1. Page one (1) of this worksheet asks you (or provider, if you wish) to enter information regarding your projections of total cost, cost adjustments, county administrative cost, number of group face-to-face visits, and average session length in minutes.

Page two (2) of the worksheet consists of protected formulas which allocate costs between funding sources, group sessions and individual sessions. The key information derived from these computations is as follows:

Line 34	Provisional per person rate for group
Line 35	Projected costs which would not be recoverable through restricted funding due to the cost per group session exceeding the rate cap.
Line 42	Provisional rate for individual sessions.
Line 43	Projected costs which would not be recoverable through restricted funding due to the cost per individual session exceeding the rate cap.

In addition to this worksheet, there is a separate worksheet version called HOURS.WK1 (hard copy enclosed, file on disk). This worksheet should be useful for financial management and for preparation of quarterly and year-end cost reports, as it will allow the entering of actual data on year-to-date costs, sessions, visits and hours. It will compute the average minutes per session and use those numbers to prorate the rate cap based on the 50 and 90 minute standards for individual and group sessions.

The worksheet diskette will accompany this letter and be sent to the County Administrators. Drug/Medi-Cal certified ODF providers may request a copy of the worksheet diskette from their County Representative. Drug/MediCal ODF Direct Contractors may request a copy of the worksheet diskette from ADP.

The Department will be providing training on the preparation and use of the worksheet. The training will likely be provided in at least four county locations by late October or early November 1995. Counties will be contacted regarding the training dates, locations and how many ODF providers may be in attendance.

4. In addition to the above, counties and providers should review FY 1995-96 claims and initiate the following edits:

   a. Do not submit Perinatal Residential claims for services on or after July 1, 1995, which were not for pregnant and postpartum women. Service costs for these women must be transferred to some other allowable funding source.

   b. Recode Perinatal OMM and Perinatal ODF claims for services on or after July 1, 1995, which were not for pregnant and postpartum women. Recode Perinatal DCH claims made before September 15, 1995, which were not for pregnant and postpartum women. These claims can be recoded from perinatal code (25) to regular D/MC.

   c. Effective the date emergency regulations are adopted limiting ODF Individual counseling to intake (including evaluation, assessment and diagnosis), crisis intervention, collateral services, and treatment and discharge planning, do not claim Units of Service or costs for individual counseling which does not meet one of these criteria.

5. Claims for Group ODF on or after August 3, 1995, should be adjusted to reflect the maximum group rate per session.

6. In order for the Department of Alcohol and Drug Programs to identify Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT) clients, it will be necessary to claim those clients separate from other clients. Federal law, which implements the EDSDT programs, requires that states provide medically necessary

services to Medi-Cal beneficiaries under 21 years of age. On a separate Drug/Medi-Cal Eligibility Worksheet, ADP 1584, claim only those clients that are EPSDT eligible. **On the top right hand side of the form print the acronym "EPSDT."** All other claiming information on the ADP 1584 will remain the same.

7. It will also be necessary to separately identify Minor Consent claims, following instructions in #6 above, printing "Minor Consent" instead of "EPSDT."

II. How Much to Claim for Outpatient Drug Free Treatment - Setting Provisional Individual and Group Rates

Costs must be allocated between Individual and Group, among Medi-Cal, Net Negotiated Amount (NNA) and Private Pay, and between Perinatal and regular D/MC. It is important for counties and providers to understand how these costs will be settled at the time of the cost report in order to calculate a realistic provisional rate. The provisional rate is calculated as follows: (total session time is in minutes)

1. The maximum allowance for an **individual session** is prorated using the percentage computed by dividing the total actual time for all sessions by the total time which would have been spent if all sessions were 50 minutes in duration. This percentage (not to exceed 100 percent) shall be applied to the maximum allowance to determine the maximum reimbursement rate.

For example:

$$\frac{Total\ Session\ Time}{(50\ mins \times Number\ of\ Sessions)} \times \$73.46 = Prorated\ Maximum\ Allowance$$

2. The maximum allowance for a **group session** is prorated using the percentage computed by dividing the total actual time for all sessions by the total time which would have been spent if all sessions were 90 minutes in duration. This percentage (not to exceed 100 percent) shall be applied to the maximum allowance to determine the maximum reimbursement rate.

To qualify as a group session there shall be at least one Medi-Cal beneficiary in a group of two or more individuals.

Total reimbursement for group session shall not exceed maximum allowance for individual session.

For example:

$$\frac{Total\ Session\ Time}{(90\ mins \times Number\ of\ Sessions)} \times \$73.46 = Prorated\ Maximum\ Allowance$$

Actual costs should be monitored at least on a quarterly basis. The provisional rates should then be revised to accurately reflect actual cost.

III. Cost Allocation Considerations

Providers and counties should conduct Individual and Group ODF treatment services consistent with the following Medi-Cal guidelines:

1. Providers should bill at a provisional rate that results in reimbursements of allowable actual costs, but not in excess of the maximum rate.

2. Costs for D/MC Services must meet the federal requirement for "lowest of actual cost, maximum rate, or customary charges."

3. Services to Medi-Cal clients must be equal in scope and duration to services provided to non-Medi-Cal clients, consistent with the requirements of medical necessity; however, not all treatment activities are reimbursable under Medi-Cal. Activities reimbursable under Medi-Cal are specifically identified in the Utilization Control Plan (UCP) and must be properly documented in clients' charts.

4. Medi-Cal beneficiaries must not be required to pay a fee other than share of cost for any portion of their treatment, regardless of whether it is reimbursable under Medi-Cal.

5. Costs attributable to Drug/Medi-Cal may not be reimbursed by other funding sources, nor may costs attributable to other funding sources be reimbursed by Drug/Medi-Cal.

   Costs of services to D/MC beneficiaries outside the D/MC benefit but otherwise allowable under Medi-Cal Fee-for-Service (FFS) must be reimbursed under Medi-Cal Fee-for-Service, unless these services are made a condition of treatment under Drug/Medi-Cal.

   Costs of services to D/MC beneficiaries outside both D/MC and Medi-Cal FFS may be

reimbursed by Negotiated Net Amount (NNA) funding sources (except that no fees may be charged to beneficiaries).

The cost of disallowed units may be reimbursed by Net Negotiated Amount (NNA) funding sources (Substance Abuse Prevention and Treatment Block Grant, discretionary State General Fund, county match funds) or any unrestricted funding source (county other and donations.) This assumes that a service was provided that qualifies for reimbursement under the other funding source. An example of a cost that could not be reimbursed under another source would be a unit of service that is disallowed because there is no documentation that a service was provided for the unit claimed.

Costs of services within the all-inclusive rate in excess of the rate cap are reimbursable only with unrestricted funds.

Particular care should be taken with allocation of costs among funding sources. Providers may have a variety of clients and treatment activities. Medi-Cal beneficiaries may be mixed with non-Medi-Cal clients; clients served under different modalities may participate in the same services; and activities may be required that are not Medi-Cal reimbursable. It is important that when implementing cost accounting procedures, Providers keep in mind the following principles:

a. Separate costs of unallowable activities: Costs for activities and objects which are allowable under Medi-Cal should be separated from those which are not allowable.

   Allowable activities are those which are specifically identified in the State Utilization Control Plan (UCP) and in federal regulation.

b. Allocate allowable costs: While some costs may be charged directly, other costs are accumulated in a single cost center for allocation. An acceptable allocation basis would be counselor time per type of client in a face-to-face treatment session. For group sessions, the counselor time would be prorated among the group participants.

c. Capture the Medi-Cal Units of Service: For ODF group counseling, the unit of service is a face-to-face group session containing at least one Medi-Cal beneficiary in a group of 2 or more clients. For ODF individual, the unit of service is a face-to-face session that meets the definition in the Drug/Medi-Cal regulations, Title 22, Section 51341.1, California Code of Regulations.

Additional Documentation Requirements

1. Providers should carefully monitor, track, and document in charts their clients' status

as Perinatal Drug/Medi-Cal beneficiaries.

2. The current claims system will not accumulate total ODF group sessions, ODF Medi-Cal group sessions, or total persons-in-group by fund source. Counties and providers must assure that their cost accounting systems collect this data.

3. Counselor/therapist time in face-to-face sessions must be documented on group rosters and individual session notes which show the beginning and ending times of sessions. Total year-to-date time for group and individual sessions must be accumulated for financial management purposes and reporting purposes. For individual sessions, the time should be accumulated by funding source for the clients served. For group sessions, only a count of clients served by funding source need be maintained to allow for allocation of total group time.

Questions

County Alcohol and Drug Program Administrators and D/MC direct contract providers who have any questions on claims submission may call Robin Rutherford, Supervisor, Fiscal Management Branch, at (916) 323-3216. For questions on completion of quarterly reports and cost reports, you may call Val Marglin, Supervisor, Fiscal Management Branch, at (916) 323-2048. Providers with county contracts should direct questions to their county representatives.

Sincerely,

GLORIA J. MERK, II
Deputy Director
Program Operations Division

Enclosure

INSTRUCTIONS FOR ODF **HOURS** WORKSHEET (ODFWS)

The ODF **Hours** Worksheet (ODFHR) may be used to develop the ODF budget, quarterly report, and cost report. Entries are only required only in the blank cells that are highlighted in yellow (shaded on hard copy). With the exception of Lines 15 and 18, all data entry is done on page 1. All non-highlighted cells contain formulas. **Please do not change any of the formulas.**

Providers will maintain the following documentation:

1. Group Sessions
   - (a) Group rosters by client name showing the payor for each client
   - (b) Date, start time, end time of the session
   - (c) Counselor's name
2. Individual Sessions
   - (a) Counselor's calendar, schedule, etc. which indicates the name of the client, date, start time, end time of every individual counseling session
3. All documentation must be traceable to client records

The following are Form ODFHR instructions:

Page 1

LINE 1 TOTAL GROSS COSTS - **Enter** the **total costs** to operate the program in Column D. These costs must be traceable to the provider's accounting records.

LINE 2 ADJUSTMENTS FOR MEDI-CAL UNREIMBURSABLE COSTS - **Enter** the costs of **services, that are program requirements,** but are not allowable within the Utilization Control Plan in Column A and Column C. The Medi-Cal share of such costs must be identified and entered as a cost chargeable to the NNA and/or Private cost center.

(For example: Some Perinatal required services, such as childcare (baby sitting), is a Perinatal requirement that is not Medi-Cal reimbursable. Also, certain SAPT Block Grant requirements for HIV and TB would not be Medi-Cal reimbursable.)

LINE 3 ADJUSTMENTS FOR DIRECT COSTS - **Enter** the costs of **services** that are applicable to a single cost center.

(For example: URC costs are a direct cost only to the Medi-Cal cost center. The amount of such costs would be indicated in the Medi-Cal cost center).

LINE 4 TOTAL ADJUSTMENTS FOR MEDI-CAL UNREIMBURSABLE AND DIRECT COSTS - **Computed by formula**. Total of all Medi-Cal unreimbursable and direct costs entered in Lines 1 and 2.

LINE 5 ADJUSTED GROSS COSTS TO BE DISTRIBUTED - **Computed by formula**. Total gross costs (LINE 1) minus total Medi-Cal unreimbursable and direct costs (LINE 4). These costs represent equal services to all clients.

LINE 6 COUNTY MEDI-CAL ADMINISTRATION - **Enter** the amount of county administration (**URC, billing, and training**) incurred by the county. These costs must be supported by the county's accounting records.

LINE 7 TOTAL COSTS (PROGRAM AND COUNTY MEDI-CAL ADMINISTRATION) - **Computed by formula**. Adds total adjustments for Medi-Cal unreimbursable and direct costs (LINE 4), adjusted gross costs to be distributed (LINE 5), and county Medi-Cal administration (LINE 6).

LINE 8 TOTAL GROUP SESSION FOR THE YEAR - **Enter** the number of group sessions held by the provider. This information must be documented by the provider. To Column "A", Line "H1", Form 7895B.

(For example, if a provider holds 2 groups sessions a day, 5 days a week, 52 weeks a year - this number will be 520).

LINE 9 NUMBER OF GROUP SESSIONS BY COST CENTER - For each cost center, **enter** the number of sessions in which at least one (1) of the cost center's clients participated. This information must be documented by the provider. To Columns B, C, and D, Line "H1", Form 7895B.

(For example, of the 520 total group sessions (LINE 8 example), review of the group rosters indicated private clients participated in 120 groups, Medi-Cal clients in 490 groups, and NNA clients in 410 groups - enter 120 (Private), 490 (Medi-Cal), and 410 (NNA).

NOTE: Since most groups sessions contain participants from all cost centers, the number of group sessions will not total to the number in Line 8.

LINE 10 TOTAL GROUP FACE TO FACE VISITS (GROUP UNITS OF SERVICE) - **Enter** the actual number of clients who participated in each of the group sessions. This information must be documented by the provider. To Line "K", Form 7895B.

See Page 14 of the Drug Program Fiscal Systems Manual for calculation of group units of service.

LINE 11 INDIVIDUAL FACE TO FACE VISITS - **Enter** one (1) unit for each individual counseling session regardless of the length of time of the session. This information must be documented by the provider. To Line "H2", Form 7895B.

LINE 12 AVERAGE MINUTES IN AN INDIVIDUAL FACE TO FACE SESSION - **Computed by formula.** Total individual hours (LINE 18) divided by the total individual face to face visits (LINE 11) multiplied by 60 (minutes).

LINE 13 AVERAGE MINUTES IN A GROUP FACE TO FACE SESSION - **Computed by formula.** Total group hours (COLUMN D, LINE 15) divided by the total group sessions for year (COLUMN D, LINE 8) multiplied by 60 (minutes).

LINE 14 PERCENT OF GROUP FACE TO FACE VISITS - **Computed by formula**. Percentage of each cost center's group units (LINE 10) to the total group units of service (COLUMN D, LINE 10). These percentages will be used in the computation of group staff hours for each cost center.

LINE 15 GROUP HOURS - **Enter** the cumulative hours recorded for all group sessions for the year in **COLUMN D, LINE 15**. The group hours for **Private, Medi-Cal, and NNA** will be **computed by the formula:**

Total group hours (COLUMN D, LINE 15) multiplied by the percent of group face to face visits (LINE 14).

LINE 16 PERCENT OF TOTAL HOURS WITHIN COST CENTER - **Computed by formula**. Within each cost center, group hours (LINE 15) divided by total staff hours (LINE 20). This percentage will be used to compute the cost of group sessions.

LINE 17 PERCENT OF INDIVIDUAL UNITS OF SERVICE - **Computed by formula**. Percentage of each cost center's individual face to face units (LINE 11) to the total individual face to face units of service (COLUMN D, LINE 11).

LINE 18 INDIVIDUAL HOURS - **Enter** the cumulative hours recorded for all individual sessions for each cost center.

LINE 19 PERCENT OF TOTAL HOURS WITHIN COST CENTER - **Computed by formula**. Within each cost center, individual hours (LINE 18) divided by total staff hours (LINE 20). This percentage will be used to compute the cost of individual counseling sessions (units).

LINE 20 TOTAL STAFF HOURS - **Computed by formula**. Group hours (LINE 15) plus individual hours (LINE 18). To Line "I", Form 7895B.

LINE 21 PERCENT OF TOTAL STAFF HOURS - **Computed by formula**. Percentage of each cost center's staff hours (LINE 20) to the total staff hours (COLUMN D, LINE 20). These percentages will be used to distribute costs to each cost center.

LINE 22 TOTAL MEDI-CAL UNREIMBURSABLE COSTS - **Computed by formula**. From PAGE 1, LINE 2s.

LINE 23 TOTAL DIRECT COSTS - **Computed by formula**. From PAGE 1, LINE 3s.

LINE 24 TOTAL DISTRIBUTED ADJUSTED GROSS COSTS - **Computed by formula**. Adjusted gross costs to be distributed (COLUMN D, LINE 5) times the percent of total staff hours (LINE 21).

LINE 25 TOTAL PROGRAM COSTS - **Computed by formula**. Adds total Medi-Cal unreimbursable costs (LINE 22), total direct costs (LINE 23), and total distributed adjusted gross costs (LINE 24) for each cost center.

LINE 26 TOTAL COSTS FOR DISTRIBUTION - **Computed by formula**.

For **Private and NNA**, the amount is from total program costs (LINE 25).

For **Medi-Cal**, adds total direct costs (LINE 23) and total distributed adjusted gross costs (LINE 24).

LINE 27 DISTRIBUTED GROUP COSTS - **Computed by formula**. Total costs for distribution (LINE 26) times percent of total (group) hours within a cost center (LINE 16).

LINE 28 TOTAL GROUP COUNTY ADMINISTRATION COSTS - **Computed by formula**. County Medi-Cal administration costs (LINE 6) multiplied by the percent of total (group) hours within cost center (LINE 16). To Line "A2", Form 7895B.

LINE 29 GROUP TREATMENT COSTS - **Computed by formula**. Adds distributed group costs (LINE 27) and total group county administration costs (LINE 28). To Line "A1", Form 7895B.

LINE 30 COST PER GROUP SESSION - **Computed by formula**. Group treatment costs (LINE 29) divided by the number of group sessions by cost center (LINE 9).

LINE 31 COST PER GROUP FACE TO FACE VISIT - Group treatment costs (LINE 29) divided by total group face to face visits (LINE 10).

LINE 32 GROUP DRUG/MEDI-CAL MAXIMUM RATE - **Computed by formula**. The maximum rate is computed based on the **average minutes in a group face to face session**. If the average minutes in a group face to face session (LINE 13) is **equal to or greater than 90 (minutes)**, the maximum rate will $73.46. If the average minutes in a group face to face session is **less than 90 (minutes)**, the maximum rate will be reduced proportionally by multiplying the CAP by the average minutes in a group session (LINE 13) divided by 90 (minutes).

(For example, the average minutes of all Medi-Cal group sessions is **81** minutes, the rate cap of $73.46 would be reduced to **$66.11** ($73.46 times 81 divided by 90).

LINE 33 MAXIMUM ALLOWABLE MEDI-CAL COSTS FOR GROUP SESSIONS - **Computed by formula**. The **lower** of the cost per group session (LINE 30) or the group Drug/Medi-Cal maximum rate (LINE 32) times the number of group sessions by cost center (LINE 9).

LINE 34 ADJUSTED COST PER GROUP FACE TO FACE VISIT (**PROVISIONAL RATE**) - **Computed by formula**. The maximum allowable Medi-Cal costs for group sessions (LINE 33) divided by the total group face to face visits (LINE 10).

LINE 35 COSTS MOVED TO UNRESTRICTED FUNDING SOURCES - **Computed by formula**. The group treatment costs (LINE 29) less the maximum allowable Medi-Cal costs for group sessions (LINE 33).

LINE 36 DISTRIBUTED INDIVIDUAL COSTS - **Computed by formula**. Total costs for distribution (LINE 26) times percent of total (individual) hours within a cost center (LINE 19).

LINE 37 TOTAL INDIVIDUAL COUNTY ADMINISTRATION - **Computed by formula**. County Medi-Cal administration costs (LINE 6) multiplied by the percent of total (individual) hours within cost center (LINE 19). To Line "B2", Form 7895B.

LINE 38 INDIVIDUAL TREATMENT COSTS - **Computed by formula**. Adds distributed individual costs (LINE 36) and total individual county administration costs (LINE 37). To Line "B1", Form 7895B.

LINE 39 COST PER INDIVIDUAL SESSION (FACE TO FACE VISIT) - **Computed by formula**. Individual treatment costs (LINE 38) divided by total individual face to face visits (LINE 11).

LINE 40 INDIVIDUAL DRUG/MEDI-CAL MAXIMUM RATE - **Computed by formula**. The maximum rate is computed based on the **average minutes in a individual face to face session**. If the average minutes in an individual face to face session (LINE 12) is **equal to or greater than 50 (minutes)**, the maximum rate will $73.46. If the average minutes in an individual face to face session is **less than 50 (minutes)**, the maximum rate will be reduced proportionally by multiplying the CAP by the average minutes in an individual session (LINE 12) divided by 50 (minutes).

(For example, the average minutes of all Medi-Cal individual sessions is **45** minutes, the rate cap of $73.46 would be reduced to **$66.11** ($73.46 times 45 divided by 50.)

LINE 41 MAXIMUM ALLOWABLE MEDI-CAL COSTS FOR INDIVIDUAL SESSIONS - **Computed by formula**. The **lower** of the cost per individual session (LINE 39) or the individual Drug/Medi-Cal maximum rate (LINE 40) times the number of individual face to face visits (LINE 11).

LINE 42 ADJUSTED COST PER INDIVIDUAL SESSION (**PROVISIONAL RATE**) - **Computed by formula**. The maximum allowable Medi-Cal costs for individual sessions (LINE 41) divided by the total individual face to face visits (LINE 11).

LINE 43 COSTS MOVED TO UNRESTRICTED FUNDS - **Computed by formula**. The individual treatment costs (LINE 38) less the maximum allowable Medi-Cal costs for individual sessions (LINE 41).

LINE 44 TOTAL REIMBURSABLE COSTS - **Computed by formula**.

For **Unrestricted funds**, adds group costs moved to unrestricted funding sources (LINE 35) and individual costs moved to unrestricted funding sources (LINE 43). Should equal Column "C", Line "G1", Form 7895B.

For **Private and NNA**, adds group treatment costs (LINE 29) and individual treatment costs (LINE 38).

For **Medi-Cal**, add the maximum allowable Medi-Cal costs for groups sessions (LINE 33) and maximum allowable Medi-Cal costs for individual sessions (LINE 41).

LINE 45 COST PER GROUP STAFF HOUR - **Computed by formula**.

For **Unrestricted**, group costs moved to unrestricted funding sources (LINE 35) divided by Medi-Cal group hours (COLUMN B, LINE 15).

For **Private and NNA**, group treatment costs (LINE 29) divided by group hours (LINE 15).

For **Medi-Cal**, maximum allowable Medi-Cal costs for group sessions (LINE 33) divided by group hours (LINE 15).

LINE 46 COST PER INDIVIDUAL STAFF HOUR - **Computed by formula**.

For **Unrestricted**, individual costs moved to unrestricted funding sources (LINE 43) divided by Medi-Cal individual hours (COLUMN B, LINE 18).

For **Private and NNA**, individual treatment costs (LINE 38) divided by individual hours (LINE 18).

For **Medi-Cal**, maximum allowable Medi-Cal costs for individual sessions (LINE 41) divided by individual hours (LINE 18).

LINE 47 COST PER TOTAL STAFF HOUR - **Computed by formula**.

For **Unrestricted**, total reimbursable costs (LINE 44) divided by total staff hours for Medi-Cal (COLUMN B, LINE 20).

For **Private, Medi-Cal, and NNA**, total reimbursable costs (LINE 44) divided by total staff hours (LINE 20).

LINE 48 TOTAL MEDI-CAL COSTS (GROUP + INDIVIDUAL TREATMENT) - **Computed by formula**. Group treatment costs (LINE 29) added to individual treatment costs (LINE 38). This is the total costs allocated to Medi-Cal and can be verified by adding total unrestricted reimbursable costs (LINE 44) to total Medi-Cal reimbursable costs (COLUMN B, LINE 44).

INSTRUCTIONS FOR ODF **AVERAGE** WORKSHEET (ODFWS)

The ODF **Average** Worksheet (ODFAVG) may be used to develop the ODF budget, quarterly report, and cost report. Entries are only required only on page 1 in the blank cells that are highlighted in yellow (shaded on hard copy). All other cells contain formulas. **Please do not change any of the formulas.**

Providers will maintain the following documentation:

1. Group Sessions
   - (a) Group rosters by client name showing the payor for each client
   - (b) Date, start time, end time of the session
   - (c) Counselor's name
2. Individual Sessions
   - (a) Counselor's calendar, schedule, etc. which indicates the name of the client, date, start time, end time of every individual counseling session
3. All documentation must be traceable to client records

The following are Form ODFAVG instructions:

Page 1

LINE 1 TOTAL GROSS COSTS - **Enter** the **total costs** to operate the program in Column D. These costs must be traceable to the provider's accounting records.

LINE 2 ADJUSTMENTS FOR MEDI-CAL UNREIMBURSABLE COSTS - **Enter** the costs of **services, that are program requirements,** but are not allowable within the Utilization Control Plan in Column A and Column C. The Medi-Cal share of such costs must be identified and entered as a cost chargeable to the NNA and/or Private cost center.

(For example: Some Perinatal required services, such as childcare (baby sitting), is a Perinatal requirement that is not Medi-Cal reimbursable. Also, certain SAPT Block Grant requirements for HIV and TB would not be Medi-Cal reimbursable.)

LINE 3 ADJUSTMENTS FOR DIRECT COSTS - **Enter** the costs of **services** that are applicable to a single cost center.

(For example: URC costs are a direct cost only to the Medi-Cal cost center. The amount of such costs would be indicated in the Medi-Cal cost center).

LINE 4 TOTAL ADJUSTMENTS FOR MEDI-CAL UNREIMBURSABLE AND DIRECT COSTS - **Computed by formula**. Total of all Medi-Cal unreimbursable and direct costs entered in Lines 1 and 2.

LINE 5 ADJUSTED GROSS COSTS TO BE DISTRIBUTED - **Computed by formula**. Total gross costs (LINE 1) minus total Medi-Cal unreimbursable and direct costs (LINE 4). These costs represent equal services to all clients.

LINE 6 COUNTY MEDI-CAL ADMINISTRATION - **Enter** the amount of county administration (**URC, billing, and training**) incurred by the county. These costs must be supported by the county's accounting records.

LINE 7 TOTAL COSTS (PROGRAM AND COUNTY MEDI-CAL ADMINISTRATION) - **Computed by formula**. Adds total adjustments for Medi-Cal unreimbursable and direct costs (LINE 4), adjusted gross costs to be distributed (LINE 5), and county Medi-Cal administration (LINE 6).

LINE 8 TOTAL GROUP SESSION FOR THE YEAR - **Enter** the number of group sessions held by the provider. This information must be documented by the provider. To Column "A", Line H1", Form 7895B.

(For example, if a provider holds 2 groups sessions a day, 5 days a week, 52 weeks a year - this number will be 520).

LINE 9 NUMBER OF GROUP SESSIONS BY COST CENTER - For each cost center, **enter** the number of sessions in which at least one (1) of the cost center's clients participated. This information must be documented by the provider. To Columns B, C, and D, Line "H1", Form 7895B.

(For example, of the 520 total group sessions (LINE 8 example), review of the group rosters indicated private clients participated in 120 groups, Medi-Cal clients in 490 groups, and NNA clients in 410 groups - enter 120 (Private), 490 (Medi-Cal), and 410 (NNA).

NOTE: Since most groups sessions contain participants from all cost centers, the number of group sessions will not total to the number in Line 8.

LINE 10 TOTAL GROUP FACE TO FACE VISITS (GROUP UNITS OF SERVICE) - **Enter** the actual number of clients who participated in each of the group sessions. This information must be documented by the provider. To Line "K", Form 7895B.

See Page 14 of the Drug Program Fiscal Systems Manual for calculation of group units of service.

LINE 11 INDIVIDUAL FACE TO FACE VISITS - **Enter** one (1) unit for each individual counseling session regardless of the length of time of the session. This information must be documented by the provider. To Line "H2", Form 7895B.

LINE 12 AVERAGE MINUTES IN AN INDIVIDUAL FACE TO FACE SESSION - **Enter** the average length of time **in minutes** of all individual face to face sessions for the year.

For example, a provider held 1,000 individual face to face sessions of various time lengths for a total of 47,200 minutes. The average minutes would be 47.20 (47,200 divided by 1000).

LINE 13 AVERAGE MINUTES IN A GROUP FACE TO FACE SESSION - **Enter** the average length of time **in minutes** of all group face to face sessions for the year. Keep in mind that school-based programs of shorter duration will reduce the average.

For example, a provider held 1,000 group sessions of various time lengths for a total of 75,000 minutes. The average minutes would be 75.00 (75,000 divided by 1000).

Page 2:

LINE 14 PERCENT OF GROUP FACE TO FACE VISITS - **Computed by formula**. Percentage of each cost center's group units (LINE 10) to the total group units of service (COLUMN D, LINE 10). These percentages will be used in the computation of group staff hours for each cost center.

LINE 15 GROUP HOURS - **Computed by formula**. The total group sessions for the year (COLUMN D, LINE 8) multiplied by the average minutes in a group face to face session (LINE 13) times the percent of group face to face visits (LINE 14).

LINE 16 PERCENT OF TOTAL HOURS WITHIN COST CENTER - **Computed by formula**. Within each cost center, group hours (LINE 15) divided by total staff hours (LINE 20). This percentage will be used to compute the cost of group sessions.

LINE 17 PERCENT OF INDIVIDUAL UNITS OF SERVICE - **Computed by formula**. Percentage of each cost center's individual face to face units (LINE 11) to the total individual face to face units of service (COLUMN D, LINE 11).

LINE 18 INDIVIDUAL HOURS - **Computed by formula**. The individual face to face visits (LINE 11) multiplied by the average minutes in an individual face to face session (LINE 12) divided by 60 (minutes).

LINE 19 PERCENT OF TOTAL HOURS WITHIN COST CENTER - **Computed by formula**. Within each cost center, individual hours (LINE 18) divided by total staff hours (LINE 20). This percentage will be used to compute the cost of individual counseling sessions (units).

LINE 20 TOTAL STAFF HOURS - **Computed by formula**. Group hours (LINE 15) plus individual hours (LINE 18). To Line "I", Form 7895B.

LINE 21 PERCENT OF TOTAL STAFF HOURS - **Computed by formula**. Percentage of each cost center's staff hours (LINE 20) to the total staff hours (COLUMN D, LINE 20). These percentages will be used to distribute costs to each cost center.

LINE 22 TOTAL MEDI-CAL UNREIMBURSABLE COSTS - **Computed by formula**. From PAGE 1, LINE 2s.

LINE 23 TOTAL DIRECT COSTS - **Computed by formula**. From PAGE 1, LINE 3s.

LINE 24 TOTAL DISTRIBUTED ADJUSTED GROSS COSTS - **Computed by formula**. Adjusted gross costs to be distributed (COLUMN D, LINE 5) times the percent of total staff hours (LINE 21).

LINE 25 TOTAL PROGRAM COSTS - **Computed by formula**. Adds total Medi-Cal unreimbursable costs (LINE 22), total direct costs (LINE 23), and total distributed adjusted gross costs (LINE 24) for each cost center.

LINE 26 TOTAL COSTS FOR DISTRIBUTION - **Computed by formula**.

For **Private and NNA**, the amount is from total program costs (LINE 25).

For **Medi-Cal**, adds total direct costs (LINE 23) and total distributed adjusted gross costs (LINE 24).

LINE 27 DISTRIBUTED GROUP COSTS - **Computed by formula**. Total costs for distribution (LINE 26) times percent of total (group) hours within a cost center (LINE 16).

LINE 28 TOTAL GROUP COUNTY ADMINISTRATION COSTS - **Computed by formula**. County Medi-Cal administration costs (LINE 6) multiplied by the percent of total (group) hours within cost center (LINE 16). To Line "A2", Form 7895B.

LINE 29 GROUP TREATMENT COSTS - **Computed by formula**. Adds distributed group costs (LINE 27) and total group county administration costs (LINE 28). To Line "A1", Form 7895B.

LINE 30 COST PER GROUP SESSION - **Computed by formula**. Group treatment costs (LINE 29) divided by the number of group sessions by cost center (LINE 9).

LINE 31 COST PER GROUP FACE TO FACE VISIT - Group treatment costs (LINE 29) divided by total group face to face visits (LINE 10).

LINE 32 GROUP DRUG/MEDI-CAL MAXIMUM RATE - **Computed by formula**. The maximum rate is computed based on the **average minutes in a group face to face session**. If the average minutes in a group face to face session (LINE 13) is **equal to or greater than 90 (minutes)**, the maximum rate will $73.46. If the average minutes in a group face to face session is **less than 90 (minutes)**, the maximum rate will be reduced proportionally by multiplying the CAP by the average minutes in a group session (LINE 13) divided by 90 (minutes).

(For example, the average minutes of all Medi-Cal group sessions is **81** minutes, the rate cap of $73.46 would be reduced to **$66.11** ($73.46 times 81 divided by 90).

LINE 33 MAXIMUM ALLOWABLE MEDI-CAL COSTS FOR GROUP SESSIONS - **Computed by formula**. The **lower** of the cost per group session (LINE 30) or the group Drug/Medi-Cal maximum rate (LINE 32) times the number of group sessions by cost center (LINE 9).

LINE 34 ADJUSTED COST PER GROUP FACE TO FACE VISIT (**PROVISIONAL RATE**) - **Computed by formula**. The maximum allowable Medi-Cal costs for group sessions (LINE 33) divided by the total group face to face visits (LINE 10).

LINE 35 COSTS MOVED TO UNRESTRICTED FUNDING SOURCES - **Computed by formula**. The group treatment costs

(LINE 29) less the maximum allowable Medi-Cal costs for group sessions (LINE 33).

LINE 36 DISTRIBUTED INDIVIDUAL COSTS - **Computed by formula**. Total costs for distribution (LINE 26) times percent of total (individual) hours within a cost center (LINE 19).

LINE 37 TOTAL INDIVIDUAL COUNTY ADMINISTRATION - **Computed by formula**. County Medi-Cal administration costs (LINE 6) multiplied by the percent of total (individual) hours within cost center (LINE 19). To Line "B2", Form 7895B.

LINE 38 INDIVIDUAL TREATMENT COSTS - **Computed by formula**. Adds distributed individual costs (LINE 36) and total individual county administration costs (LINE 37). To Line "B1", Form 7895B.

LINE 39 COST PER INDIVIDUAL SESSION (FACE TO FACE VISIT) - **Computed by formula**. Individual treatment costs (LINE 38) divided by total individual face to face visits (LINE 11).

LINE 40 INDIVIDUAL DRUG/MEDI-CAL MAXIMUM RATE - **Computed by formula**. The maximum rate is computed based on the **average minutes in a individual face to face session**. If the average minutes in an individual face to face session (LINE 12) is **equal to or greater than 50 (minutes)**, the maximum rate will $73.46. If the average minutes in an individual face to face session is **less than 50 (minutes)**, the maximum rate will be reduced proportionally by multiplying the CAP by the average minutes in an individual session (LINE 12) divided by 50 (minutes).

(For example, the average minutes of all Medi-Cal individual sessions is **45** minutes, the rate cap of $73.46 would be reduced to **$66.11** ($73.46 times 45 divided by 50.)

LINE 41 MAXIMUM ALLOWABLE MEDI-CAL COSTS FOR INDIVIDUAL SESSIONS - **Computed by formula**. The **lower** of the cost per individual session (LINE 39) or the individual Drug/Medi-Cal maximum rate (LINE 40) times the number of individual face to face visits (LINE 11).

LINE 42 ADJUSTED COST PER INDIVIDUAL SESSION (**PROVISIONAL RATE**) - **Computed by formula**. The maximum allowable Medi-Cal costs for individual sessions (LINE 41) divided by the total individual face to face visits (LINE 11).

LINE 43 COSTS MOVED TO UNRESTRICTED FUNDS - **Computed by formula**. The individual treatment costs (LINE 38) less the maximum allowable Medi-Cal costs for individual sessions (LINE 41).

LINE 44 TOTAL REIMBURSABLE COSTS - **Computed by formula**.

For **Unrestricted funds**, adds group costs moved to unrestricted funding sources (LINE 35) and individual costs moved to unrestricted funding sources (LINE 43). Should equal Column "C", Line "G1", Form 7895B.

For **Private and NNA**, adds group treatment costs (LINE 29) and individual treatment costs (LINE 38).

For **Medi-Cal**, add the maximum allowable Medi-Cal costs for groups sessions (LINE 33) and maximum allowable Medi-Cal costs for individual sessions (LINE 41).

LINE 45 COST PER GROUP STAFF HOUR - **Computed by formula**.

For **Unrestricted**, group costs moved to unrestricted funding sources (LINE 35) divided by Medi-Cal group hours (COLUMN B, LINE 15).

For **Private and NNA**, group treatment costs (LINE 29) divided by group hours (LINE 15).

For **Medi-Cal**, maximum allowable Medi-Cal costs for group sessions (LINE 33) divided by group hours (LINE 15).

LINE 46 COST PER INDIVIDUAL STAFF HOUR - **Computed by formula**.

For **Unrestricted**, individual costs moved to unrestricted funding sources (LINE 43) divided by Medi-Cal individual hours (COLUMN B, LINE 18).

For **Private and NNA**, individual treatment costs (LINE 38) divided by individual hours (LINE 18).

For **Medi-Cal**, maximum allowable Medi-Cal costs for individual sessions (LINE 41) divided by individual hours (LINE 18).

LINE 47 COST PER TOTAL STAFF HOUR - **Computed by formula**.

For **Unrestricted**, total reimbursable costs (LINE 44) divided by total staff hours for Medi-Cal (COLUMN B, LINE 20).

For **Private, Medi-Cal, and NNA**, total reimbursable costs (LINE 44) divided by total staff hours (LINE 20).

LINE 48 TOTAL MEDI-CAL COSTS (GROUP + INDIVIDUAL TREATMENT) - **Computed by formula**. Group treatment costs (LINE 29) added to individual treatment costs (LINE 38). This is the total costs allocated to Medi-Cal and can be verified by adding total unrestricted reimbursable costs (LINE 44) to total Medi-Cal reimbursable costs (COLUMN B, LINE 44).